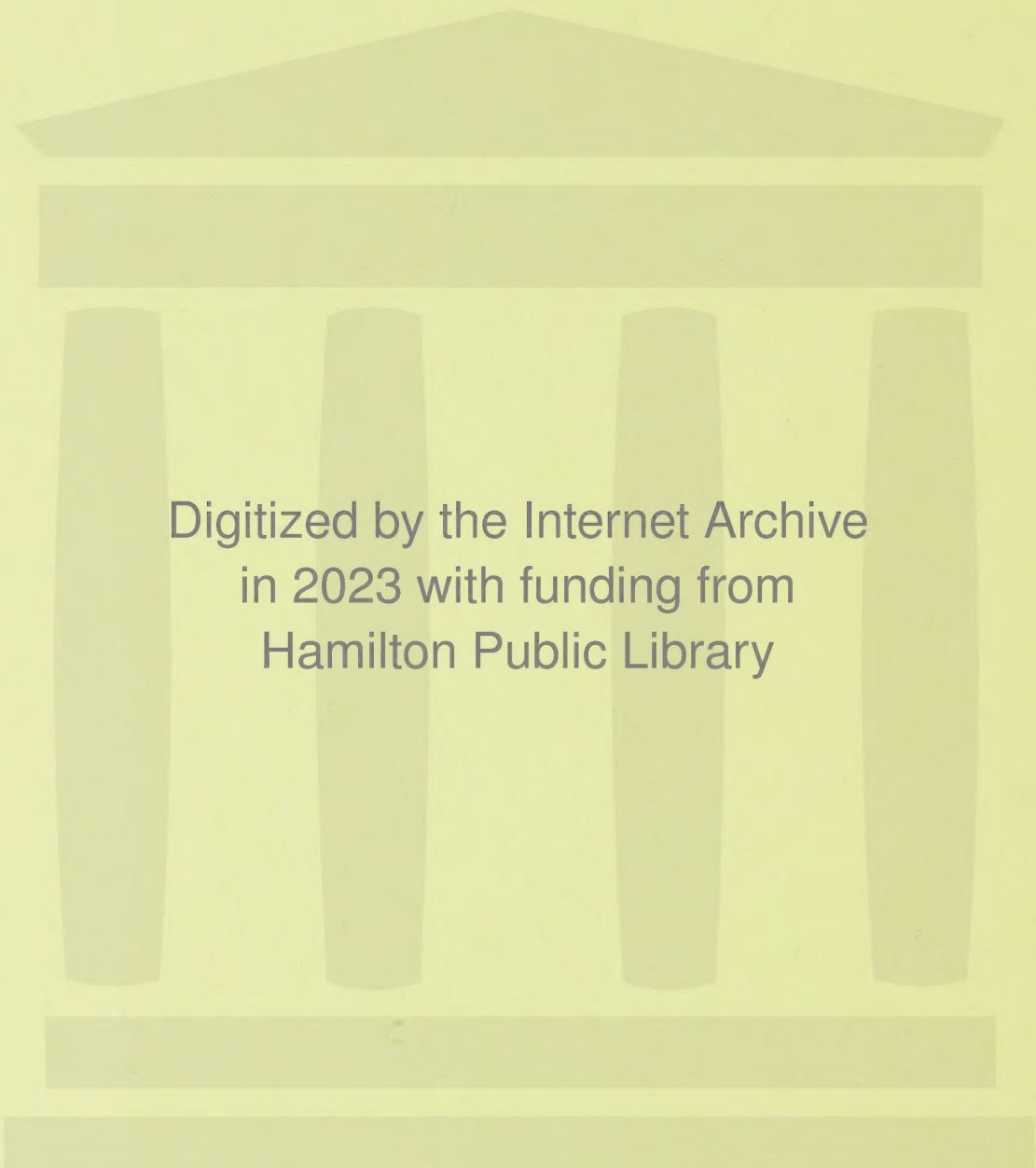
ANNUAL REPORT

Assessment and Placement Service of the Hamilton Wentworth District Health Council

APS

1976



FIFTH ANNUAL REPORT
OF THE
ASSESSMENT AND PLACEMENT SERVICE
OF THE
HAMILTON WENTWORTH DISTRICT HEALTH COUNCIL

MANAGEMENT COMMITTEE

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Secretary	Mrs. K. Milne
Clerk/Stenographer	Mrs. J. (McMahon) Beckerson

1. Resigned September 1976
2. Appointed during 1976

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HISTORICAL BACKGROUND

The A.P.S. was established by the Hamilton District Health Council in 1971 on the advice of the then newly formed Extended Care Committee. The project was funded in April of that year by the Ontario Ministry of Health and commenced operation in September 1971.

One of the concerns of the Health Council has been the promotion of optimal utilization of the services for the disabled and chronically ill. The Extended Care Committee was formed to study the needs of this group and the services available. The result of their discussions was the recommendation that a coordinating body be formed to obtain the medical, social and nursing evaluations of the disabled and chronically ill and make recommendations of the appropriate programs or levels of care for the development of the individual's assets and potential.

The Health Council appointed a medical consultant and two members of the health professions to provide the coordinating evaluation function; a part time administrator and secretarial staff; and a data analyst to maintain statistics for the evaluation of the service's efficacy and the provision of an information base for future planning in the health needs of the disabled.

ASSESSMENT FORM

Prior to commencement of operation an Assessment tool was developed to provide the necessary information for appropriate recommendation. Broadly, this information falls into three categories:

(a) demographic (age, sex, marital status, next of kin, education, employment and cultural background, present location and level of income)

(b) medical (diagnosis, prognosis, treatment, level of cognitive function, emotional status)

(c) functional capacity (degree of ability to walk, talk, see, hear, comprehend, dress, bathe, undertake personal care and household care).

The demographic and functional capacity data is provided by a social worker-nurse team for the hospitalized applicant and by the Public Health, Victorian Order or St. Elizabeth Nurse for those applicants at home. The medical information is provided by the applicant's personal physician.

RECOMMENDATIONS

Recommendations are made on the basis of the information provided by the Health Care team with additional input as indicated and with an intimate knowledge of the available facilities and programs.

Recommendations include appropriate level of care, and/or programs of rehabilitation or recreation, and programs whereby the disabled person may be assisted toward a meaningful role in society.

REFERRAL PROCESS

Referrals are made by health professionals in the community or health care institutions and/or members of the community, and may be as simple as a telephone call asking for the process to be set in motion.

DEFINITIONS:

Assessment - the evaluation of the needs, capabilities, and assets of the applicants from the information supplied by physicians, nursing and social services and other health professionals.

Placement - the identification and recommendation of the most suitable program(s) to meet the applicant's needs and develop his/her potential capabilities, and facilitation of the movement of the applicant to the site of the program(s) or the movement of the program(s) to the individual.

Referral Form - the A.P.S. designed form used by the health professionals to provide demographic, medical, environmental and cultural background information on the applicant. Revised January 1976.

MEDICAL CONSULTANT'S REPORT

- J.R.D. Bayne, M.D., F.R.C.P. (C)., F.A.C.P. -

THE PROFESSIONAL ROLE OF THE ASSESSMENT & PLACEMENT SERVICE

The Assessment & Placement Service (A.P.S.) uses a form to gain a picture of the applicant on the basis of which an A.P.S. Counsellor makes a recommendation of a type of program that would seem appropriate to the needs indicated. The A.P.S. is advisory to health professionals to enable them to function more effectively. In other words, it is a professional service.

It was decided to use a form in order to ensure that each health professional made a basic assessment of the social, psychological and physical needs of the patient prior to requesting assistance or placement in a special service or program. The use of a form also made it clear that the responsibility for the patient's management remains with the same health professional or team of professionals.

The form contains sufficient detail to enable the Counsellor who receives it at the A.P.S. office to identify if there are discrepencies in observations relating to diagnosis, mental and physical status, services required in the future, medications and future program requested. Further clarification is often obtained by telephone. The Medical Consultant to A.P.S. may be involved in contacting the physician to clarify a diagnosis or to suggest management. The recommendation of the Counsellor is based on what is required according to this picture and what is available or could be made available. The referring professionals must decide whether to act on this or not, and must help the patient adjust to the new plans. A.P.S. has the effect of guiding, enabling and monitoring the outcome for each applicant.

The A.P.S. also has the function of collecting data for evaluation of effectiveness of the various programs and services. The assessment form is partially precoded making it possible to obtain a picture of the services required. The recommendations and placements are coded so that use of services and any deficiencies in them can be determined for action by the Health Council and planners.

PROBLEM AREAS:

Two general problem areas have been identified
(a) difficulties health professionals have in assessing specific needs and responding to them, and
(b) difficulties that exist in the provision of appropriate services and programs for certain groups of people with special problems.

One of the difficulties with individual assessments seems to be in establishing a clear diagnosis in some elderly people who are confused and especially in those who become aggressive or disturbed. Impaired mental function is commonly recorded but the diagnoses of senility, cerebral arteriosclerosis or chronic brain syndrome are apparently used interchangeably and other possibilities may not have been considered. The management prior to referral is not always consistent and health professionals seem not informed on the appropriate treatment approach, on how to work together, on the use of medications or on the involvement of family members. This is not to say that the assessment is wrong, rather the form may clearly reveal that there is a knowledge deficiency among health professionals in some aspects of diagnosis and management. The value of the A.P.S. approach is that it allows a clearer picture to be gained of these deficiency areas so that Counsellor or Medical Consultant can offer advice and information. Further improvement in services can be promoted through the education programs of the Health Sciences faculties of McMaster University and Mohawk College for both practising professionals and students.

In a majority of referrals there is a problem in the availability of appropriate services and programs. Judging from the waiting lists it might be assumed that there is a major deficiency in residential care accommodation. This could be true if it is agreed that a high proportion of disabled people, especially the elderly, should be in long stay institutions. Ontario already has a high proportion of its elderly citizens in institutions. Perhaps this is because not enough alternatives such as community support programs have been offered. *Such alternatives to be acceptable must be readily available, less expensive for the individual and family than institutional care, not restricted in service to daylight hours and the usual working days, multidisciplinary, coordinated and consistent. They must be mobilized long before a crisis arises and be on-going as long as the need exists.* The family, neighbours, volunteers and the general public must be involved and supportive. Such a program is not inexpensive but as an alternative to what is now being provided by the health budget should not be exhorbitant.

The concept of community support programs is not new, and has been extensively used in Britain. There are, however, several concerns that must be examined in setting up such services. These are the administration, control of utilization, evaluation of effectiveness, assurance of quality care and appropriateness of referral. Although the services may be inexpensive compared to hospital care, the costs are not negligible and the service can tie up scarce health professionals. Therefore, one must ensure that for a person to receive the services there must be an initial assessment to identify the extent of need, and re-evaluation must occur at intervals. For the initial assessment of needs the A.P.S. form can be used without requiring a duplicate team of health professionals. For the assurance of quality care of community programs and evaluation of effectiveness for the individual better methodology is required than now exists and work is being done on this.

Emerging from the analysis of the information obtained from A.P.S. has come a clearer picture of what action to take. The Hamilton Wentworth District Health Council has recognized the need for coordination and evaluation of all services for the aged, and for further education and professional support for health professionals. It has authorized the development of a Program in Geriatrics and Gerontology with responsibility to provide backup consultation and to ensure that assessment and specific treatment is available to meet the various needs of each individual. This program will promote the improvement or expansion of services (such as institutional or community care) as the need is shown. Education of all types of health professionals and students can be provided both in the course of patient management and by specific lecutres, demonstrations etc. to meet any inadequacies. The existing hospital, community, and residential care facilities will be included in total planning. A backup group of geriatric consultants will be engaged with a small assessment unit for specific difficult cases. Evaluation of effectiveness will be on-going.

In summary, future developments in the management of chronic illness in this district will have three major thrusts. There will be the use of A.P.S. for the assessment of individual needs and the identification of an appropriate program. There will be the use of information from A.P.S. on educational and consultation needs of practising professionals so that management and services can be improved. There will be the use of A.P.S. data and other methodology to evaluate the use of existing resources and what modifications or new approaches are needed.

ADMINISTRATOR'S REPORT

Joyce Caygill

1976 has been a year of considerable activity for A.P.S. The new precoded Referral Form was introduced January 1, 1976. A new Policies and Procedures manual was produced, changes in office procedures were developed and all staff cooperated with Woods, Gordon Company in an Evaluation Study of A.P.S. The latter was commissioned by the Hamilton-Wentworth District Health Council in cooperation with the Ontario Ministry of Health. A Steering Committee to supervise the study was Chaired by Mr. A. Butler, architect, of Hamilton with representatives from the Ministry of Health, Hamilton-Wentworth District Health Council, Ontario Nursing Home Association, Ontario Ministry of Community & Social Services, Hamilton-Wentworth Public Health Department, and the Hamilton Academy of Medicine. Six companies presented proposals for the study with Woods, Gordon Company being the successful candidate. The completed study was to be submitted to the Steering Committee on January 21, 1977. The new precoded Referral Form has proved very satisfactory for statistical purposes. We are confident that our data provides clear, accurate and up-to-date pictures of the population we are endeavouring to serve. Data is coded and keypunched twice a week, statistical overview of individuals awaiting placement and the locations of placement are produced on a regular monthly basis. The statistics relating to numbers awaiting placement in acute care hospitals, private residence, and other facilities are forwarded monthly to Hospital Administrators, Directors of Social Work Departments, Hamilton-Wentworth District Health Council and other agencies involved in the planning and delivery of health care.

SERVICE

REFERRALS

During 1976 we were involved with 2897 cases of which 2346 were referred in 1976. 2197 cases were closed between January 1 and December 31, 1976, and provide the data base for much of this report. Patterns of referrals according to age, sex, marital status, diagnoses etc. established in previous years have not changed. We consistently see more females than males requiring long term care, females outlive males. Generalized ischemic cerebrovascular disease heads the list of diagnoses in frequency occurence (368) followed by chronic ischemic heart disease (362) (see p.16). Of the 2541 diagnoses recorded 1294 are directly related to cerebral impairment (some clients have more than one diagnosis).

Arteriosclerosis, tenth on the 1975 list was eleventh in 1976 (152 cases reported), fracture of the neck of the femur which was ninth in 1975 placed twelfth in 1975 (151).

The list of diagnoses is reinforced by the data showing impairment in memory and judgement as recorded by physicians on the B1 and B2 pages of the Referral Form. 1492 had some impairment of memory, including 529 who were severely impaired (incomplete data: 284). 1664 had some impairment in judgement, including 552 who were severely impaired (incomplete data: 282).

Of the 2197 completed cases only 421 were considered to have normal memory, and 251 normal judgement (p. 17). The 2005 cases recorded in 1975 showed similar results, 1333 had some impairment of memory, 497 were severely impaired (incomplete: 258). 1488 had some impairment of judgement, 494 were severely impaired (incomplete: 258). Also of interest was the high incidence of non ambulatory clients, only 492 were considered to be fully ambulatory, 1424 were not fully ambulatory (incomplete data: 281).

WAITING LISTS

Waiting lists have continued to increase with an average of 540 persons awaiting placement at any time during the year. Peak month was December with 594 and lowest month July with 468. Highest month in 1975 was July with 570, lowest March with 357. Peaks and lows do not seem to be predictable from year to year as we had previously anticipated.

1974 High - September, Low - January

1975 - July - March

1976 - December - July

Sample month: November 1976. Location of persons awaiting admission to a program were as follows.

In acute treatment hospitals awaiting admission to:

Nursing Homes	101
Chronic Hospitals	86
Homes for the Aged	39
Rehabilitation Units	6
Services in Community	19
	251

At home or in other facilities awaiting admission to:		
Nursing Homes	130	
Chronic Hospitals	51	
Homes for the Aged	80	
Rehabilitation Units	3	
Services in Community	64	
	328	
TOTAL		579

(see also Table on p. 18)

PLACEMENT

1623 placements were made in 1976, 1355 were first placement, 222 second, and 46 third placements. (Some clients require more than one placement before final is reached, i.e. client in active treatment centre requires first placement in rehabilitation setting with second placement in nursing home) (p. 15). 348 clients died before final placement, 94 died within 90 days of placement, 30 within 14 days of placement. 535 cases refused or did not require placement. 259 experienced a change in condition which necessitated a change in recommendation. 700 cases were still active on December 31, 1976.

CLIENT SATISFACTION

As mentioned in our 1975 report we commenced an automatic follow-up procedure one month following placement. Preliminary survey indicated that 66% of those who would respond would report satisfaction. The response rate during the first months of 1976 was slow, when we introduced a stamped addressed envelope the response rate increased noticeably. Of the 1349 follow-up letters sent to client or family we had 96% satisfaction rate from those who responded (821 satisfied, 35 not satisfied, 493 no response). 1322 follow-up letters were sent to facilities and there the satisfaction rate of those who responded was 98% (797 satisfied, 17 not satisfied, 508 no response). In some cases where a client or family did not respond a further letter was sent to the facility - which accounts for the large number of follow-up letters. When we received a "Not satisfied" response the Counsellor originally involved immediately contacted either the client, a family member or the professional in the program to determine the areas of dissatisfaction. The reasons for dissatisfaction were varied and ranged from

family resentment, guilt or feelings of inadequacy, through dissatisfaction with the level of care or physical location, to changes in the client's condition. In some cases re-referral was instituted, but, when family members preferred the client to be in an acute care institution, we were unable to accomplish total family satisfaction.

IDENTIFICATION OF NEEDS WITHIN THE COMMUNITY

PLACING THE "YOUNG" CLIENT

We continue to experience difficulty placing the person under 60 who requires long term care in a setting which will recognize the attitudes and expectations of the younger person and be able to provide the stimulus of hobbies, recreation and social contact. We use the term "young" for those under 60 or for those whose mental outlook is youthful and vigorous.

The Chedoke Continuing Care Centre offers a program for the young chronically ill person, but, there is no nursing home facility which caters exclusively to the younger client. The Cerebral Palsy Association plans to open in 1977 a Participation House which could accommodate the younger person who would benefit from private living quarters and an on-site recreation and workshop program. There has been discussion in Hamilton-Wentworth and Halton Counties of development of the Cheshire Homes concept which caters to the disabled who do not require regular nursing care but who may require assistance with personal care. The residents combine their homemaking skills and abilities in order to live as independently as possible. We hope that 1977 will see the opening of some of the above facilities but we will still require a nursing home type of care for the more severely disabled person who wishes to live as normally as possible within his/her ability. Many nursing homes in this area which have one or more of these young and relatively dynamic persons have expressed concern for their well being. Other homes have refused to accept younger persons because of a reluctance to see them placed with an elderly, frequently confused, residential population. The clients who fall into this category are few, approximately 150 per year, but the difficulty encountered in placing them and the unsuitability of many placements makes them a prominent group.

THE CONFUSED, AMBULANT ELDERLY

Reference was made in the Medical Consultant's Report of 1975 to the high frequency of impairment in memory and judgement associated with the diagnosis of organic brain disease in applicants. We continue to experience difficulty in placing the confused but ambulatory person in an appropriate setting. The Homes for the Aged have facilities which protect the resident from wandering away from a special care area and offer programs designed specifically for this group.

However, the waiting period for such accommodation is prolonged to the point that alternate accommodation must be sought. Nursing Homes have accepted many of these people and have designed programs for their needs. However, few nursing homes have premises which protect the confused person from wandering away, and this presents a problem for the staff in maintaining constant supervision. The size of this group is small, but the problems encountered in placement and care give it a high profile.

A study of this problem was made in 1976 and has been accepted for publication in the Canadian Journal of Public Health. In addition, this material has been made available to local organizations involved in planning future projects.

EDUCATION

A.P.S. Counsellors visit acute care hospitals on a regular, once-a-week basis to discuss particular problems in placement with Social Work or Nursing Department representatives and to attend team conferences on request (e.g. Regional Head Injury Program, Multiple Sclerosis Clinic, Chedoke Continuing Care Admissions Conference).

Members of A.P.S. have also acted as resource persons to a variety of social and health care associations, e.g. Visiting Homemakers, Social Planning and Research Council, Domiciliary Care Committee, Victorian Order of Nurses, Hamilton-Wentworth Group on Aging, Junior League of Hamilton, Wentworth Lodge Home for the Aged to name but a few.

DATA USAGE

We have endeavoured to be available to all areas of health care in the Region and Province as a source of information. Requests to explain the A.P.S. system and types of long term care facilities have been received from Schools of Social Work, Departments of Nursing Education both undergraduate and graduate, and from local social care and action agencies. We have responded to all of these requests by sending the most appropriate representative from A.P.S. to speak to these groups and answer questions. In addition, we have had many contacts with local planning authorities in other areas of Ontario and elsewhere which are considering development of similar agencies.

Statistical information regarding the non-medical use of drugs, tobacco and alcohol has been made available to McMaster University for use in a larger study under the Non Medical Use of Drugs Directorate, Ottawa (Lowell Gerson, M.D. et al).

A.P.S. has also provided background information for various studies on admission criteria for acute care hospitals, for studies of the confused, ambulant person, and has

used data to identify problem areas requiring consideration and action by others. We have been in continuous contact with the Ministry of Health providing data for cross checking purposes and the identification of study needs.

FUTURE DEVELOPMENT

In the past the three objectives of A.P.S.

a) promoting better assessment of the needs of persons with long term disabilities utilizing the personal physician and other health personnel closely associated with the patient

b) finding appropriate programs that could meet these needs and identifying whatever modifications or new approches might be required

c) providing a resource for the education of health personnel in the complex needs of the chronically ill and handicapped. (see page 16, A.P.S. Annual Report, 1972)

have, of necessity been blended in order to accomplish the development of all three simultaneously. Now we believe we are in a position to view these as separate functions and pursue them as need dictates. We are aware that the Woods, Gordon study has shown many health professionals to be uncertain where A.P.S. responsibility in the field of counselling begins or ends. Our stated philosophy of providing an advisory service to health professionals with no attempt on our part to step between the professionals and his/her client perhaps needs to be reemphasized. (1973 Report p.1(a)).

The accumulation of data and the constancy of patterns should enable us to be more precise in our identification of program needs and/or modifications. We hope that our suggestions and resource material will enable community health planners to aggressively develop programs to cater to the needs of specific populations. (i.e. the young severely disabled, the confused ambulatory elderly). In the event a geriatric assessment centre becomes a reality in Hamilton we will become a valuable source of statistical material in the developmental stages and during operation. The role of A.P.S. staff as resource persons in the education of health personnel has been described earlier in this report. We may not be able to increase our educational activities but we intend to be more vigorous in discussions regarding the roles health professionals play and in the definitions of responsibility of A.P.S. towards health professionals and their clients.

LOCATION AT TIME OF REFERRAL

Location		
Joseph Brant Hospital	124	
Chedoke Hospital	98	
Henderson Hospital	239	1034
St. Joseph's Hospital	282	
Hamilton General Hospital	212	
*M.U.M.C. (Hospital)	79	
**H-W.B. Community	804	
Other H-W.B. facilities	208	
Facilities other than H-W.B. areas	70	
Community other than H-W.B.	50	
Missing data	31	

*M.U.M.C. = McMaster University Medical Centre

**H-W.B. = Hamilton-Wentworth Region and Burlington

N = 2197

LOCATION OF PLACEMENT

Location	H-W.B.*	Outside H-W.B.	Outside Ontario	
Chronic Hospitals	202	7		
Nursing Homes	409	15		
Homes for the Aged	115	14		
Rehabilitation	105	--		
Ham. Psych. Hospital	15	--		
Homes for Spec. Care	3	--		
Other facilities	1	10		
Private residence	228	17		
Lodging house	111	1		
Day Care Centre	47	--		
Home Care Program	126	--		
Other	9	2		
Active Treatment Hospitals	186	9		
	---		4	
TOTALS	1557	65	4	1626

*H-W.B. = Hamilton-Wentworth Region and Burlington

TEN MOST FREQUENTLY LISTED DIAGNOSES

Number of Diagnoses recorded 5733

Number of different Diagnoses recorded 307

Average number of Diagnoses per referral 2.61

Diagnosis	Absolute Frequency	Percentage of 5733
1 Generalized ischemic cerebro-vascular disease	368	6.4
2 Chronic ischemic heart disease	362	6.3
3 Symptomatic heart disease	297	5.2
4 Cerebral thrombosis	291	5.1
5 Other cerebral paralysis	251	4.4
6 Diabetes mellitus	234	4.1
7 Essential benign hyperten-sion	198	3.4
8 Senile and presenile de-mentia	197	3.4
9 Psychosis associated with other cerebral condition	187	3.3
10 Osteoarthritis and allied conditions	156	2.7
	2541	44.3

MEMORY - recorded by Attending Physician on page 1, Assessment Form, Section B., 1976.

1 Normal	421
2 Brief periods of forgetfulness	472
3 Brief periods of confusion	491
4 Periods of marked confusion	409
5 No recall	120
Missing information	284
TOTAL	2197

JUDGEMENT

1 Normal	251
2 Adequate for personal safety	483
3 Limited	629
4 Gross impairment - unrealistic	296
5 Unable to make any judgement	256
Missing information	282
TOTAL	2197

THREE YEAR COMPARISON OF WAITING LISTS FOR THE MONTH OF NOVEMBER

In acute treatment hospitals awaiting placement

Facility required	1974	1975	1976
Nursing Homes	75	65	101
Chronic Hospitals	44	67	86
Homes for the Aged	15	16	39
Rehabilitation Units		15	6
Support Services		14	19
Total in hospital	134	177	251

In the community awaiting placement

Facility required	1974	1975	1976
Nursing Homes	91	66	130
Chronic Hospitals	15	25	51
Homes for the Aged	68	58	60
Rehabilitation Units	6	3	3
Support Services	38	68	4
Total in community	218	220	328
Total awaiting placement	352	397	579

OPERATING EXPENSES

	year end - Dec 31, 76	Dec 31, 75
Salaries	116,854	100,397
Employee benefits	10,854	8,382
Office Space	11,220	*5,684
Advertising	136	369
Insurance	250	228
Business Machines	1,759	1,545
Postage	965	497
Office supplies	2,408	4,886
Telephone	2,081	1,991
Travel	1,231	917
Data processing	4,074	3,343
Staff training	71	200
Audit	500	-
Other	88	64
	152,224	129,738

* low figure due to use of temporary quarters in 1975

TYPES OF CARE

(extract: Patient Care Classification by Types of Care, Ontario Ministry of Health publication #75-2222 8/75, pp3-4)

TYPE 1 (RESIDENTIAL CARE)

Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

TYPE 2 (EXTENDED HEALTH CARE)

Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 3 (CHRONIC)

Care required by a person who is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 4 (SPECIAL REHABILITATIVE CARE)

Care required by a person with relatively stable disability such as congenital defect, post-traumatic deficits or the disabling sequelae of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this TYPE OF CARE is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

TYPE 5 (ACUTE)

Care required by a person:

a) who presents a need for investigation, diagnosis or for definition of treatment requirements for a known, an unknown, or potentially serious condition; and/or

b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or

c) who is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.

TERMINOLOGY IN COMMON USE IN ONTARIO

TYPE 1 CARE

Where provided

Homes for the Aged
Charitable institutions
Nursing homes
Foster homes
Group homes
Boarding homes
Homes for special care (residential care)
Children's institutions
Homes for unmarried mothers

Terminology

Domiciliary care
Ambulant care
Normal care
Residential care
"Intermediate care" in nursing homes
Community (social) support programs
(mental):
- day care
- sheltered workshops
- supervised recreation

TYPE 2 CARE

Where provided

Homes for the Aged
Nursing homes
Homes for special care (nursing homes)
Children's institutions

Terminology

Extended health care
Extended care
Homes for special care programs

TYPE 3 CARE

Where provided

Chronic hospitals
Chronic care units in general hospitals
Nursing homes approved for chronic care
Geriatric units in psychiatric hospitals
Special facilities (schedule II) for mentally retarded with physical handicap
Children's institutions

Terminology

Chronic care
Care of the chronically ill
Chronic hospital care
Psycho-geriatric units (psychiatric hospital)

TYPE 4 CARE

Where provided

Regional rehabilitation centres

Terminology

Special rehabilitation care
Rehabilitation

TYPE 5 CARE

Where provided

Public hospitals
Private hospitals
(G.H.P.U.) psychiatric units of general hospitals
Provincial psychiatric hospitals
Private psychiatric hospitals
Community psychiatric hospitals
Children's mental health centres

Terminology

Acute care
Active treatment
Psychiatric care (short and medium term)

ACKNOWLEDGEMENTS

We continue to enjoy the support and cooperation of the providers of health care in this area and we are grateful for their willingness to participate in the evaluation study completed by Woods, Gordon Company.

We have received great assistance and guidance from McMaster University Computation Services Unit, and from the Regional Service Program, Dept. of Clinical Epidemiology and Biostatistics, McMaster University (Grant RD6) and we are indebted to them for their patience.

NOTES

Data was accessed using the Statistical Package for the Social Sciences (SPSS) software package on the CDC 6400 of McMaster University

Codes include:

Diagnosis	ICDA - 8 (International Classification of Diseases adapted for American use)
Location by facility	Ministry of Health Ministry Information System Division Data Development & Evaluation Branch Master Numbering System, 1976
Location by area	Ontario Postal Region Code
Physician	Medical Directory of the College of Physicians and Surgeons of Ontario

Mailing address for the Assessment & Placement Service:
Box 2085, Hamilton, Ontario

Telephone: 385-5361